House of Representatives

File No. 743

General Assembly

February Session, 2016 ***(Reprint of File No. 487)***

Substitute House Bill No. 5451
As Amended by House Amendment
Schedule "A"

Approved by the Legislative Commissioner
April 27, 2016

AN ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH'S RECOMMENDATIONS FOR VARIOUS REVISIONS TO THE OFFICE OF HEALTH CARE ACCESS STATUTES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subsection (a) of section 19a-486d of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) The commissioner shall deny an application filed pursuant to subsection (d) of section 19a-486a unless the commissioner finds that: (1) In a situation where the asset or operation to be transferred provides or has provided health care services to the uninsured or underinsured, the purchaser has made a commitment to provide health care to the uninsured and the underinsured; (2) in a situation where health care providers or insurers will be offered the opportunity to invest or own an interest in the purchaser or an entity related to the purchaser, safeguard procedures are in place to avoid a conflict of interest in patient referral; and (3) certificate of need authorization is justified in accordance with chapter 368z. The commissioner may

contract with any person, including, but not limited to, financial or actuarial experts or consultants, or legal experts with the approval of the Attorney General, to assist in reviewing the completed application. The commissioner shall submit any bills for such contracts to the purchaser. Such bills shall not exceed one hundred fifty thousand dollars. Upon the filing of an application pursuant to subsection (d) of section 19a-486a, the purchaser shall establish an escrow account pursuant to a formal escrow agreement provided by the Office of Health Care Access for the purpose of paying bills submitted by the commissioner. The purchaser shall initially fund the escrow account with one hundred fifty thousand dollars. The **[**purchaser**]** escrow agent shall pay such bills **[**no**]** out of the escrow account directly to the expert or consultant not later than thirty days after the date of receipt of **[**such bills**]** each bill by the purchaser.

Sec. 2. Subsection (j) of section 19a-639f of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(j) The office shall retain an independent consultant with expertise on the economic analysis of the health care market and health care costs and prices to conduct each cost and market impact review, as described in this section. The office shall submit bills for such services to the purchaser, as defined in subsection (d) of section 19a-639. **[**Such purchaser**]** Upon the filing of an application involving the transfer of ownership of a hospital, the purchaser shall establish an escrow account pursuant to a formal escrow agreement provided by the Office of Health Care Access for the purpose of paying the bills for services provided by the independent consultant. The purchaser shall initially fund the escrow account with two hundred thousand dollars. The escrow agent shall pay such bills out of the escrow account directly to the independent consultant not later than thirty days after receipt of each bill by the purchaser. Such bills shall not exceed two hundred thousand dollars per application. The provisions of chapter 57, sections 4-212 to 4-219, inclusive, and section 4e-19 shall not apply to any agreement executed pursuant to this subsection.

Sec. 3. Subsection (d) of section 19a-638 of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(d) The Commissioner of Public Health may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the commissioner holds a public hearing prior to implementing the policies and procedures and prints notice of intent to adopt regulations in the Connecticut Law Journal not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted. **[**Final regulations shall be adopted by December 31, 2011.**]**

Sec. 4. Subdivision (2) of subsection (j) of section 19a-508c of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(2) Such notice shall <u>be worded to be general in nature and not specific to the individual patient and</u> include the following information:

(A) A statement that the health care facility is now a hospital-based facility and is part of a hospital or health system;

(B) The name, business address and phone number of the hospital or health system that is the purchaser of the health care facility;

(C) A statement that the hospital-based facility bills, or is likely to bill, patients a facility fee that may be in addition to, and separate from, any professional fee billed by a health care provider at the hospital-based facility;

(D) (i) A statement that the patient's actual financial liability will depend on the professional medical services actually provided to the patient, and (ii) an explanation that the patient may incur financial

liability that is greater than the patient would incur if the hospital-based facility were not a hospital-based facility;

(E) The estimated amount or range of amounts the hospital-based facility may bill for a facility fee or an example of the average facility fee billed at such hospital-based facility for the most common services provided at such hospital-based facility; and

(F) A statement that, prior to seeking services at such hospital-based facility, a patient covered by a health insurance policy should contact the patient's health insurer for additional information regarding the hospital-based facility fees, including the patient's potential financial liability, if any, for such fees.

Sec. 5. Subdivision (1) of subsection (l) of section 19a-508c of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(l) (1) Each hospital, as defined in section 19a-646, and its affiliated health system shall report not later than July 1, 2016, and annually thereafter to the Commissioner of Public Health concerning facility fees charged or billed during the preceding calendar year. Such report shall include (A) the name and location of each facility owned or operated by the hospital or health system that provides services for which a facility fee is charged or billed, (B) the number of patient visits at each such facility for which a facility fee was charged or billed, (C) the number, total amount and range of allowable facility fees paid at each such facility by Medicare, Medicaid or under private insurance policies, (D) for each facility, the total amount of revenue received by the hospital or health system derived from facility fees, (E) the total amount of revenue received by the hospital or health system from all facilities derived from facility fees, (F) a description of the ten procedures or services that generated the greatest amount of facility fee revenue and, for each such procedure or service, the total amount of revenue received by the hospital or health system derived from facility fees, and (G) the top ten procedures for which facility fees are

charged based on patient volume. For purposes of this subsection, "facility" means a hospital-based facility that is located outside a hospital campus.

Sec. 6. Subsections (g) to (i), inclusive, of section 19a-486i of the 2016 supplement to the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(g) Not later than **[**December 31, 2014**]** January 15, 2017, and annually thereafter, each hospital and hospital system shall file with the Attorney General and the Commissioner of Public Health a written report describing the activities of the group practices owned or affiliated with such hospital or hospital system. Such report shall include, for each such group practice: (1) A description of the nature of the relationship between the hospital or hospital system and the group practice; (2) the names and specialties of each physician practicing medicine with the group practice; (3) the names of the business entities that provide services as part of the group practice and the address for each location where such services are provided; (4) a description of the services provided at each such location; and (5) the primary service area served by each such location.

(h) Not later than **[**December 31, 2014**]** January 15, 2017, and annually thereafter, each group practice comprised of thirty or more physicians that is not the subject of a report filed under subsection (g) of this section shall file with the Attorney General and the Commissioner of Public Health a written report concerning the group practice. Such report shall include, for each such group practice: (1) The names and specialties of each physician practicing medicine with the group practice; (2) the names of the business entities that provide services as part of the group practice and the address for each location where such services are provided; (3) a description of the services provided at each such location; and (4) the primary service area served by each such location.

(i) Not later than **[**December 31, 2015**]** January 15, 2017, and

annually thereafter, each hospital and hospital system shall file with the Attorney General and the Commissioner of Public Health a written report describing each affiliation with another hospital or hospital system. Such report shall include: (1) The name and address of each party to the affiliation; (2) a description of the nature of the relationship among the parties to the affiliation; (3) the names of the business entities that provide services as part of the affiliation and the address for each location where such services are provided; (4) a description of the services provided at each such location; and (5) the primary service area served by each such location.

Sec. 7. Subsection (e) of section 19a-632 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(e) If any assessment is not paid when due, the commissioner shall impose a fee equal to (1) two per cent of the assessment if such failure to pay is for not more than **[**five**]** seven days, (2) five per cent of the assessment if such failure to pay is for more than **[**five**]** seven days but not more than fifteen days, or (3) ten per cent of the assessment if such failure to pay is for more than fifteen days. If a hospital fails to pay any assessment for more than thirty days after the date when due, the commissioner may, in addition to the fees imposed pursuant to this subsection, impose a civil penalty of up to one thousand dollars per day for each day past the initial thirty days that the assessment is not paid. Any civil penalty authorized by this subsection shall be imposed by the commissioner in accordance with subsections (b) to (e), inclusive, of section 19a-653.

Sec. 8. Subsection (e) of section 19a-632a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(e) Where any assessment is treated under subsection (d) of this section as an assessment not made in a timely manner because it is made by means other than electronic funds transfer, there shall be

imposed a penalty equal to ten per cent of the assessment required to be made by electronic funds transfer. Where any assessment made by electronic funds transfer is treated under subsection (d) of this section as an assessment not made in a timely manner because the bank account designated by the department is not credited by electronic funds transfer for the amount of the assessment on or before the date such assessment is due, there shall be imposed a penalty equal to (1) two per cent of the assessment required to be made by electronic funds transfer, if such failure to pay by electronic funds transfer is for not more than **[**five**]** seven days; (2) five per cent of the assessment required to be made by electronic funds transfer, if such failure to pay by electronic funds transfer is for more than **[**five**]** seven days but not more than fifteen days; or (3) ten per cent of the assessment required to be made by electronic funds transfer, if such failure to pay by electronic funds transfer is for more than fifteen days.

Sec. 9. Section 19a-634 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

[(a) The Office of Health Care Access shall conduct, on a biennial basis, a state-wide health care facility utilization study. Such study may include an assessment of: (1) Current availability and utilization of acute hospital care, hospital emergency care, specialty hospital care, outpatient surgical care, primary care and clinic care; (2) geographic areas and subpopulations that may be underserved or have reduced access to specific types of health care services; and (3) other factors that the office deems pertinent to health care facility utilization. Not later than June thirtieth of the year in which the biennial study is conducted, the Commissioner of Public Health shall report, in accordance with section 11-4a, to the Governor and the joint standing committees of the General Assembly having cognizance of matters relating to public health and human services on the findings of the study. Such report may also include the office's recommendations for addressing identified gaps in the provision of health care services and recommendations concerning a lack of access to health care services.**]**

[(b)**]** (a) The **[**office**]** Office of Health Care Access, in consultation with such other state agencies as the Commissioner of Public Health deems appropriate, shall establish and maintain a state-wide health care facilities and services plan. Such plan may include, but not be limited to: (1) An assessment of the availability of acute hospital care, hospital emergency care, specialty hospital care, outpatient surgical care, primary care and clinic care; (2) an evaluation of the unmet needs of persons at risk and vulnerable populations as determined by the commissioner; (3) a projection of future demand for health care services and the impact that technology may have on the demand, capacity or need for such services; and (4) recommendations for the expansion, reduction or modification of health care facilities or services. In the development of the plan, the office shall consider the recommendations of any advisory bodies which may be established by the commissioner. The commissioner may also incorporate the recommendations of authoritative organizations whose mission is to promote policies based on best practices or evidence-based research. The state-wide health care facilities and services plan shall include a state-wide health care facility utilization study. Such study may include an assessment of: (A) Current availability and utilization of acute hospital care, hospital emergency care, specialty hospital care, outpatient surgical care, primary care and clinic care; (B) geographic areas and subpopulations that may be underserved or have reduced access to specific types of health care services; and (C) other factors that the office deems pertinent to health care facility utilization. The commissioner, in consultation with hospital representatives, shall develop a process that encourages hospitals to incorporate the state-wide health care facilities and services plan into hospital long-range planning and shall facilitate communication between appropriate state agencies concerning innovations or changes that may affect future health planning. The office shall update the state-wide health care facilities and services plan not less than once every two years.

[(c)**]** (b) For purposes of **[**conducting the state-wide health care facility utilization study and**]** preparing the state-wide health care

facilities and services plan, that shall include the results of the state-wide healthcare facility utilization study, the office shall establish and maintain an inventory of all health care facilities, the equipment identified in subdivisions (9) and (10) of subsection (a) of section 19a-638, and services in the state, including health care facilities that are exempt from certificate of need requirements under subsection (b) of section 19a-638. The office **[**shall develop**]** may utilize an inventory questionnaire to obtain the following information: (1) The name and location of the facility; (2) the type of facility; (3) the hours of operation; (4) the type of services provided at that location; and (5) the total number of clients, treatments, patient visits, procedures performed or scans performed in a calendar year. The inventory shall be completed **[**biennially**]** every three years by health care facilities and providers and such health care facilities and providers shall not be required to provide patient specific or financial data.

Sec. 10. Subsection (c) of section 19a-654 of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(c) An outpatient surgical facility, as defined in section 19a-493b, a short-term acute care general or children's hospital, or a facility that provides outpatient surgical services as part of the outpatient surgery department of a short-term acute care hospital shall submit to the office the data identified in subsection **[**(c)**]** (b) of section 19a-634, as amended by this act. The office shall convene a working group consisting of representatives of outpatient surgical facilities, hospitals and other individuals necessary to develop recommendations that address current obstacles to, and proposed requirements for, patient-identifiable data reporting in the outpatient setting. On or before February 1, 2012, the working group shall report, in accordance with the provisions of section 11-4a, on its findings and recommendations to the joint standing committees of the General Assembly having cognizance of matters relating to public health and insurance and real estate. Additional reporting of outpatient data as the office deems necessary shall begin not later than July 1, 2015. On or before July 1,

2012, and annually thereafter, the Connecticut Association of Ambulatory Surgery Centers shall provide a progress report to the Department of Public Health, until such time as all ambulatory surgery centers are in full compliance with the implementation of systems that allow for the reporting of outpatient data as required by the commissioner. Until such additional reporting requirements take effect on July 1, 2015, the department may work with the Connecticut Association of Ambulatory Surgery Centers and the Connecticut Hospital Association on specific data reporting initiatives provided that no penalties shall be assessed under this chapter or any other provision of law with respect to the failure to submit such data.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2016*	19a-486d(a)
Sec. 2	*October 1, 2016*	19a-639f(j)
Sec. 3	*October 1, 2016*	19a-638(d)
Sec. 4	*October 1, 2016*	19a-508c(j)(2)
Sec. 5	*October 1, 2016*	19a-508c(l)(1)
Sec. 6	*October 1, 2016*	19a-486i(g) to (i)
Sec. 7	*October 1, 2016*	19a-632(e)
Sec. 8	*October 1, 2016*	19a-632a(e)
Sec. 9	*October 1, 2016*	19a-634
Sec. 10	*October 1, 2016*	19a-654(c)

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact: None

Municipal Impact: None

Explanation

The bill, which makes various revisions to Office of Health Care Access statutes, does not result in a fiscal impact to the state or municipalities.

House "A" eliminated three sections of the underlying bill, which did not result in a fiscal impact.

The Out Years

State Impact: None

Municipal Impact: None

OLR Bill Analysis

sHB 5451 (as amended by House "A")*

AN ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH'S RECOMMENDATIONS FOR VARIOUS REVISIONS TO THE OFFICE OF HEALTH CARE ACCESS STATUTES.

SUMMARY:

This bill makes the following changes to statutes related to the Department of Public Health's (DPH) Office of Health Care Access (OHCA):

1. requires purchasers in certain hospital ownership transfers to establish escrow accounts to pay for consultants OHCA hires to help review certificate of need (CON) applications and conduct cost and market impact reviews (§§ 1 & 2);

2. modifies facility fee notice and reporting requirements for certain hospitals and health systems (§§ 4 & 5);

3. changes, from December 31 to January 15, the date by which certain hospitals, hospital systems, and group physician practices must annually report specified information to the DPH commissioner and attorney general (§ 6);

4. modifies the timeframes in which hospitals are charged late fees for failing to pay the annual assessment to cover OHCA's costs (§§ 7 & 8); and

5. changes OHCA reporting requirements by combining the office's statewide health care facility utilization study with its statewide health care facilities and services plan, which it must complete every three years instead of biennially (§ 9).

The bill also makes technical and conforming changes.

*House Amendment "A" eliminates the provisions in the underlying bill (File 487) on CON penalties and the CON exemption for replacing certain imaging equipment.

EFFECTIVE DATE: October 1, 2016

§§ 1 & 2 — CON FOR NONPROFIT HOSPITAL SALES

Escrow Account for Experts Assisting With CON Review

Current law allows OHCA to contract with experts or consultants to help review a CON application that proposes to transfer ownership of a nonprofit hospital to a for-profit purchaser (i.e., "hospital conversions") and bill the purchaser up to $150,000 for these experts' services.

The bill requires the purchaser, when filing the CON application with OHCA and the attorney general, to establish an escrow account to pay bills the DPH commissioner submits for the experts' services. OHCA must provide the purchaser with a formal escrow agreement, and the purchaser must initially fund the escrow account with $150,000.

Under the bill, the escrow agent must pay the bills directly to the expert or consultant out of the escrow account within 30 days after receiving each bill. Current law requires the purchaser to pay these bills within the same timeframe.

Escrow Account for Cost and Market Impact Review

The law requires OHCA to conduct a cost and market impact review (CMIR) of CON applications for hospital ownership transfers if the purchaser is (1) an in- or out-of-state hospital or a hospital system that had net patient revenue exceeding $1.5 billion for fiscal year 2013 or (2) organized or operated for profit.

By law, OHCA must hire an independent consultant to conduct the CMIR and bill the purchaser up to $200,000 for the consultant's services. The bill requires the purchaser to establish an escrow account to pay for the consultant's services in the same manner as described

above, except that the purchaser must initially fund the escrow account with $200,000. The escrow agent must pay the consultant's bills from the escrow account within 30 days after receiving a bill.

§§ 4 & 5 — FACILITY FEES

Acquired Physician Group Practices - Patient Notice

Existing law requires hospitals or health systems that purchase physician group practices to notify the practice's patients served in the previous three years of any facility fees they will likely charge. The bill specifies that the notice must be worded to be general in nature and not patient-specific.

Among other things, the law requires the notice to include a statement (1) that the physician group practice is now a hospital-based facility and part of a hospital or health system and (2) estimating facility fee amounts or examples of average facility fees charged for common services.

Hospital and Health System Reporting Requirements

Existing law requires each hospital and health system to annually report to the DPH commissioner on the facility fees it charged or billed the prior year at hospital-based facilities outside a hospital campus. The bill limits the reporting requirement to short-term acute care hospitals, children's hospitals, and their affiliated health systems.

§ 6 — REPORTING REQUIREMENTS FOR CERTAIN HOSPITALS AND GROUP PRACTICES

By law, each hospital or hospital system with an affiliated physician group practice and unaffiliated physician group practices of 30 or more physicians must report specified information annually to the DPH commissioner and attorney general. The bill changes, from December 31 to January 15, the date by which they must submit the reports.

Existing law requires the reports to include, among other things, (1) the names and specialties of each physician in the group practice; (2) a

description of services provided at each location; and (3) for an affiliated group practice, the nature of the relationship between the hospital or hospital system and the group practice.

§§ 7 & 8 — HOSPITAL ASSESSMENT FOR OHCA'S COSTS

By law, short-term acute care hospitals and children's hospitals are assessed annually for OHCA's costs. Under current law, failure to pay an assessment on time results in a late fee equal to (1) 2% of the assessment if the failure to pay is for five days or less and (2) 5% of the assessment if the failure to pay is for more than five days but less than 15 days. The bill extends the minimum thresholds from five to seven days.

Under current law and the bill, a hospital that fails to pay an assessment for more than 15 days is fined 10% of the assessment. If a hospital fails to pay an assessment for more than 30 days after it is due, the commissioner may, in addition to these fees, impose a civil penalty of up to $1,000 for each day past the initial 30 days that the assessment is not paid.

§ 9 — STATEWIDE HEALTHCARE FACILITIES AND SERVICES PLAN

The bill eliminates the requirement that OHCA biennially conduct a statewide health care facility utilization study that addresses the following:

1. current availability and utilization of acute hospital care, hospital emergency care, specialty hospital care, outpatient surgical care, and primary and clinic care;

2. geographic areas and subpopulations that may be underserved or have reduced access to specific types of health care services; and

3. other factors the office considers pertinent to facility utilization.

It instead requires OHCA to include this information in its

statewide health care facilities and services plan. Under the bill, OHCA must complete the plan every three years instead of biennially.

By law, OHCA must maintain an inventory of all health care facilities, equipment, and services in the state in order to prepare the plan. The bill allows, rather than requires, the office to use an inventory questionnaire to obtain the inventory information.

COMMITTEE ACTION

Public Health Committee

Joint Favorable
Yea 19 Nay 9 (03/21/2016)